

Caregiving in Georgia

A Second Report



A State Report
Prepared by Dr. Kathy Scott, R.N., C.
For the Georgia Division of Aging Services

Summer, 2003



Jim Martin, Commissioner
Maria Greene, Division Director

Georgia Department of Human Resources
Division of Aging Services • Two Peachtree Street, NW • Suite 9.398 • Atlanta, Georgia 30303-3142 • (404) 657-5258

Dear Friend:

In 2002 the Department of Human Resources Division of Aging Services published the first comprehensive “state of the State” report on the issue of caregiving for older Georgians. Our goal, was and continues to be, to define issues, so that we can make informed decisions about where we should commit our resources, both fiscal and human, in program development.

The research was conducted through a series of focus groups composed of a variety of caregivers, both traditional family caregivers and paid professionals and para-professionals. They were anxious to share their experiences, those both gratifying as well as frustrating. The central theme of “compassion fatigue” emerged from both types of caregivers, and three significant related issues were identified -

that caregivers, regardless of their relationship to those
for whom they provide care, need more information and
assistance;

that the needs for supports and services exceed the
resources available;

and

that many providers of supports and services are “ageist”

Because we were interested in the views of other groups of caregivers, we continued the focus groups into 2003, concentrating on obtaining input from more family caregivers, as well as those of staff in the Georgia Long Term Care Ombudsman Program, which protects the rights of residents of long-term care facilities. Kathy Scott, Ph.D., R.N., C., continued as our consultant-partner in the caregiver research

We are pleased to offer this addendum to our original report, with findings which are consistent and which provide an even more comprehensive view of caregiving in Georgia. We hope this additional information will assist policy makers, the aging network and caregivers to make more informed decisions in this very critical area of long term care.

Sincerely,

Maria Greene, Director
Division of Aging Services

Acknowledgments

The Division of Aging Services would like to thank the following individuals and organizations for their contributions to this second report:

Focus Group Participants

Once again, we want to acknowledge and thank the many focus group participants who were willing to share their time and experiences in order to assist others in gaining a more in-depth understanding of caregiving for older adults in Georgia.

Georgia Area Agency on Aging Directors and Staff

These individuals were invaluable in locating caregivers in their areas to participate in the focus groups.

Programs Assisting Community Elderly, Inc. (P.A.C.E.)

Kathy Scott, R.N.,C., Ph.D., President
11205 Alpharetta Highway, Suite B1-A
Roswell, GA 30076
(770) 754-3146

Dr. Scott conducted the focus group research and prepared the report.

Graphic Designer

Margie Wong, R.N., B.S.N., MBA
margie_wong@bellsouth.net

**Georgia Department of Human Resources
Division of Aging Services**

Two Peachtree Street, NW
Suite 9.398
Atlanta, GA 30303-3142
(404) 657-5258

Beverly Littlefield, Section Manager for Program Development and Operations
Cliff Burt, MPA, Caregiver Specialist

Digital Vision, who graciously allowed the use of their photography in this report.

Individuals whose photographs are included in this report are not actual caregivers interviewed for this research.

Table of Contents

Letter from Maria Greene, Director, GA Division of Aging Services 1
Acknowledgments 2
Table of Contents 3
Summary of Caregiver Report 2002 5
Results 5
Actions Taken to Create a Two-Way Flow of Information 6
Actions Taken to Improve Direct Services 6
Actions Taken to Bolster Training 7
Actions Taken to Support Service Providers 7
Additional Focus Groups, 2003 9
Research Approach 9
Sample and Setting 9
Focus Group Procedures 9
Focus Group Sample Demographic Data 10
State of Georgia Planning and Service Areas Map 11
Focus Group Results 13
Contextual Perspectives: Compassion Fatigue and Frustration 13
Mode of Entry 14
Double and Triple Duty Care 15
Level of Care Intensity 16
Caregiver Health Issues 18
Six Major Experiential Themes 19
Lack of Information and Coordination of Resources 19
Needs Exceed Availability 21
Ageist Providers 22
The Lone Caregiver 24
Pushing Against the Tide 26
Living a Dilemma 27
Focus Group Recommendations 31
Strategic Plan for Caregiver Initiatives 32
References 34
Area Agencies on Aging Resource Information 35

Summary of Caregiver Report 2002

Results

The following three pages represent a synopsis of the *Caregiving in Georgia* report of 2002. Please refer to this report for more detailed information via the website, www.dhr.state.ga.us. Pages 9 through 30 represent the data from five new focus groups conducted in 2002 and 2003.

A focus group approach was used as the primary data collection method to explore the meaning of the caregiving experience of six caregiver subgroups, 64 individuals, from different areas of Georgia (see table, page 10). The subgroups included family members [spouses, daughters, and granddaughters], community members who were providing volunteer care at various sites, paid professionals from a variety of disciplines [nursing, social work, care management, law, and aging services], and nursing assistants in home care and home health care.^{1,2}

An analysis was completed using a phenomenological methodology^{1,2} to determine the themes that existed throughout the six focus groups. Out of the context of "Compassion Fatigue and Frustration," three major themes emerged for these caregivers which included 1) Lack of Information/Coordination of Services, 2) Needs Exceed Availability, and 3) Ageist Providers.

The overarching theme of "Compassion Fatigue and Frustration" is best described as the constant state of willingness, weariness, and frustration of the caregivers as they forged ahead in an attempt to provide the care they perceived to be needed. The state of fa-

tigue and frustration seemed to be highly influenced by the caregivers' underlying beliefs and expectations about caregiving activities.^{1,2}

Lack of Information/Coordination of Services was one of the three major themes, reflecting the need for easier access to information on 1) what services and products were available, 2) clarity on what was included in those services, and 3) assistance in locating the services, products, and reimbursement sources. In some cases, the caregivers suggested that finding assistance [information or services] was as or more difficult than providing care itself.

Needs Exceed Availability was the second major theme. This theme reflected the frustration caregivers experienced around the lack of funding or lack of services available to address the needs that existed during the caregiving process. The lack of availability or assistance was particularly acute in relation to medications, transportation, home care, geriatricians, nursing assistants, and nursing home beds.

Ageist Providers was the essence of the third major theme. Caregivers repeatedly described the frustration in their experience with health care providers that were not knowledgeable in the care of older adults. Additionally, many were concerned over the lack of supervision or monitoring of the nursing assistants responsible for care in the home.

It is out of the context of "Compassion Fatigue and Frustration" and the three major themes that approximately 40 rec-



ommendations were generated by the six subgroups.^{1,2} These recommendations were intended for a wide audience for the purpose of addressing the concerns revealed during the focus groups. Some of the recommendations required funding while others included “no cost” interventions such as including family caregivers on social service organization boards. The following is a synopsis of the activities and initiatives that have occurred as a result of the recommendations from the original report.

1. Actions Taken to Create a Two-Way Flow of Information:

- * Caregiver focus group findings were shared with the Area Agencies on Aging (AAA's) for use in developing their four-year area plans. The results were also shared at the Rosalyn Carter Annual Caregiving Conference, and the Annual Women's Health Forum. A presentation was made at the Division's Annual Nutrition Conference, with a new track, *Balancing Careers and Caregiving*.
- * Five additional focus groups have been conducted with Long-Term Care Ombudsman program staff and family caregivers from across Georgia.
- * *Caregiving in Georgia* report, with support from AARP, has been printed and disseminated statewide to selected committees on the Georgia General Assembly, AAAs, AARP, members of COAGE, Georgia Council on Aging, and other public and private sector organizations. The report can be accessed via the Department of Human Resources website, www.dhr.state.ga.us, which is going to be the home page for the Division of Aging Services.
- * A list of caregiving Internet Resources has been compiled and disseminated to AAAs.

2. Actions Taken to Improve Direct Services

- * The Georgia Cares program has been designed and implemented state-wide to educate and help seniors apply for all available low-cost prescription drug assistance programs.
- * Georgia's *Mobile Day Care* program, an innovative service delivery model which enables rural communities to have their own day care program several days per week while sharing staff that travel between locations, has been featured in the rural health section of *Successful Farming Magazine*.
- * AAAs allocated over \$750,000 of new funding available through the National Family Caregiver Support Program for respite services.
- * Several AAAs are expanding options available to family caregivers for over-night in-home or out-of-home respite.
- * The Rosalynn Carter Institute has received funding from the U.S. Administration on Aging to develop CARE-NETs within six AAA regions of Georgia. CARE-NETs are collaborative networks of representatives of professional and family caregiving organizations, as well as individuals, that work together to develop service and educational programs for caregivers.
- * Several AAAs are providing counseling for caregivers either in the home or through forums.
- * Several AAAs have developed programs and services for grandparents raising grandchildren, including counseling, support groups, health monitoring, and mentoring.

- * A number of AAAs are employing caregiver specialists to assist family caregivers.

3. Actions Taken to Bolster Training

- * With leadership provided by the Georgia Council on Aging, the Georgia Alliance for Staffing Solutions was formed. This network of 30 agencies and organizations has sponsored two forums to explore possible solutions to the crisis in long-term care staffing.
- * With funding from the Georgia Caregiver Resource Center (GCRC), the Division provides funding to four AAAs per year to develop regional caregivers forums. Some forums will provide respite care to care receivers, enabling family caregivers to be able to attend. The Rosalynn Carter Institute has presented at some of these events.
- * Division staff chaired plenary sessions and workshop tracks at several Georgia Gerontology Society Annual Meetings which highlighted issues such as the crisis in long-term care staffing, developing career ladders for nursing assistants, and self-directed care voucher programs.
- * Area Agencies on Aging sponsored caregiving trainings and forums with funding from the National Family Caregiver Support Program.
- * Beginning in 2002, the Greater Georgia Chapter of the Alzheimer's Association received funding from the Georgia General Assembly to provide 26 education/training sessions to family and professional caregivers around the state. The funding is on-going.
- * The State office of AARP has begun an education/training program to enhance knowledge and skills of nursing aides, with sessions provided across the state.

- * Through CARE-NETs established by the Rosalynn Carter Institute and participating Area Agencies on Aging, several *Caring for You, Caring for Me* forums for family caregivers have been conducted.

4. Actions Taken to Support Service Providers

- * Through a national competitive grant process, the Division received funding from the U.S. Administration on Aging (AoA) for a self-directed program, enabling caregivers to hire family and friends to provide services. Georgia received the third highest grant awarded by the AoA for these funds from the National Family Caregiver Support Program.
- * Division and AARP staff were successful in developing a special track for nursing assistants at the 2001 Georgia Gerontology Society Meeting; over 140 nursing assistants attended.
- * Numerous education/training initiatives have begun, and are listed above in “Actions Taken to Bolster Training.”
- * Policies and Procedures for adult day care/adult day health, respite, senior centers, homemaker, nutrition services, and personal care have been developed and revised. These policies establish requirements to be followed when AAAs provide or contract for the provision of services.
- * Review guides to assist AAA staff to measure compliance and performance of services have been developed or revised. These guides are for nutrition services, care management, home repair, respite, information and referral, elder legal assistance programs, outreach, and adult day care/adult day health.

Additional Focus Groups, 2003

A. Research Approach

As in the original report, a focus group approach was the primary data-collection method and the phenomenological methodology was used to analyze the data of the most recent groups.

B. Sample and Setting

The sample for these five groups was persons who give care to older adults in the state of Georgia. The selection was expanded from the first report to include two groups of ombudsman program staff, and to better represent the predominant caregiver to older adults, three additional groups of family members were included. Participants were selected from five different areas of the state in order to broaden the perspective of the caregiving experience. (See map, page 11.)

Groups 7 and 8: Non-Traditional/ Professional

These groups of caregivers represented all 12 regions of the state and included state ombudsman and their supervisors.

Groups 9,10, and 11: Traditional/ Non-Professional

These groups represented family members from predominantly rural settings in Northwest, Southeast, and Coastal Georgia. Family members providing care were spouses and children.

C. Focus Group Procedures

The focus group team was the same group as described in the original report. The focus group procedures for recruitment of participants, the collection of data, the sample questions and analysis also remained the same.^{1,2}



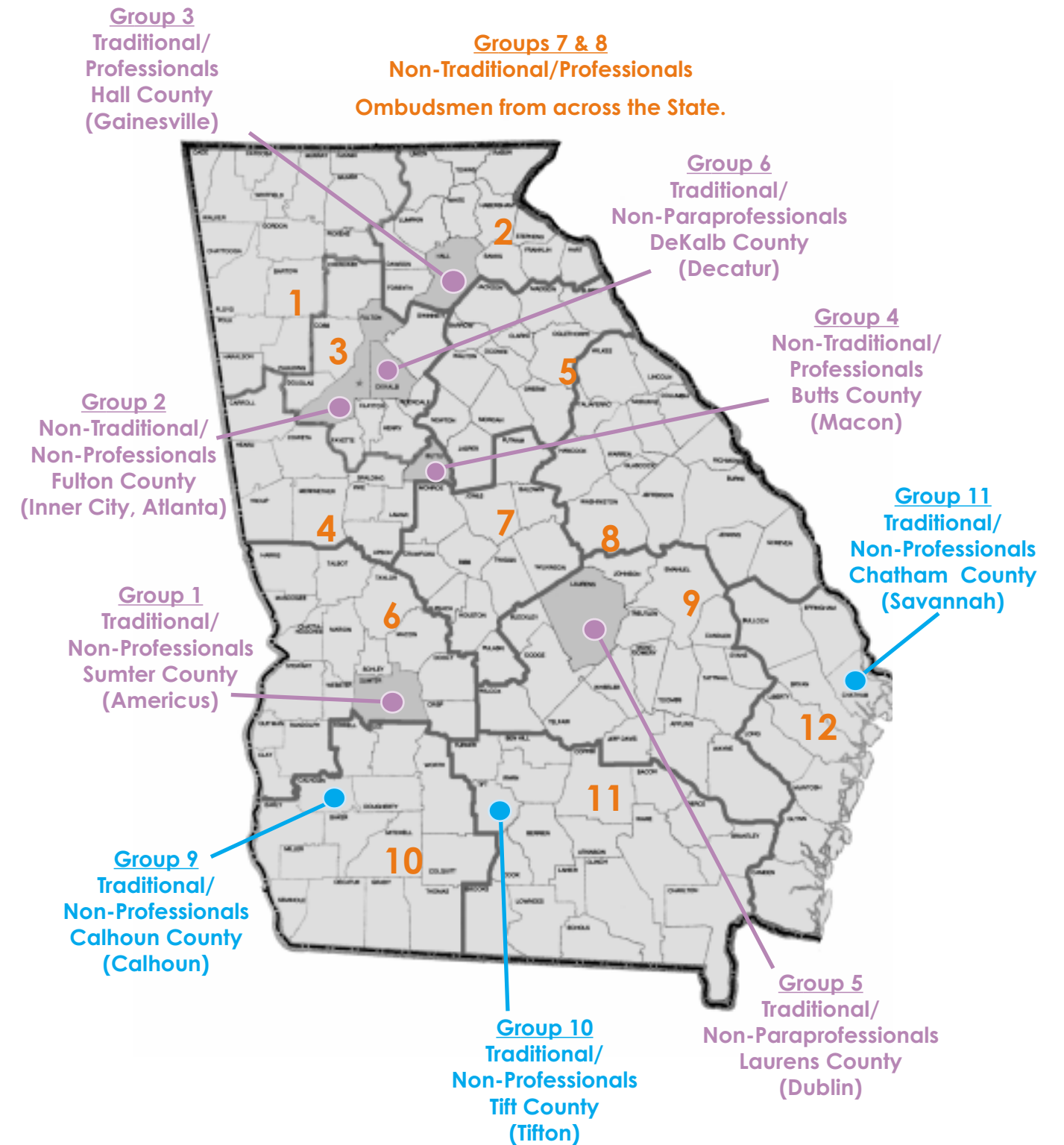
In many families, it is often difficult for an outsider to determine who might be in need of care or who is providing the care.

Focus Group Sample Demographic Data

The focus group results from the original report--groups 1 through 6--are represented in purple. The second set of focus group results is represented in blue, and the tan area is the total of all groups.

	TOTAL IN GROUP	GENDER		AGE RANGE	RACE			
		FEMALE	MALE		AFRICAN-AMERICAN	HISPANIC / LATINO	CAUCASIAN	ASIAN / NOT SPECIFIED
GROUP 1 TRADITIONAL, NON-PROFESSIONAL	12	9	3	40-80	0	0	11	1
GROUP 2 NON-TRADITIONAL, NON-PROFESSIONAL	11	9	2	29-80	6	0	3	2
GROUP 3 TRADITIONAL PROFESSIONAL	14	13	1	38-61	2	0	12	0
GROUP 4 NON-TRADITIONAL PROFESSIONAL	8	5	3	33-52	3	0	5	0
GROUP 5 TRADITIONAL NON-PARA-PROFESSIONAL	11	11	0	26-69	6	0	5	0
GROUP 6 TRADITIONAL NON-PARA-PROFESSIONAL	8	8	0	35-56	7	1	0	0
GROUPS 7 & 8 NON-TRADITIONAL, PROFESSIONAL	30	28	2	33-71	4	0	24	2
GROUP 9 TRADITIONAL, NON-PROFESSIONAL	6	3	3	40-70	0	0	6	0
GROUP 10 TRADITIONAL, NON-PROFESSIONAL	13	11	2	40-76	2	0	11	0
GROUP 11 TRADITIONAL, NON-PROFESSIONAL	10	9	1	42-83	4	0	6	0
TOTALS:	123	106 (86%)	17 (14%)	Range 26-83	34 (27.6%)	1 (.8%)	83 (67.5%)	5 (4%)

State of Georgia Planning and Service Areas Map Focus Group Sites



The counties colored purple were included in the original Caregivers report that was published in 2002. Those in blue, as well as the ombudsmen from the 12 districts (indicated with an asterisk), were added in 2003 and are part of this report.

Focus Group Results

Compassion Fatigue



Frustration

Contextual Perspectives: Compassion Fatigue and Frustration

Consistent with the previous six participant groups, “Compassion Fatigue and Frustration” served as the overarching theme for the caregiving experience of these participants. Although the majority were in their roles willingly and by choice, most of them shared stories that were wrapped in exasperation and exhaustion.

- ◆ *“We all have a lot of sleepless nights, I think.”*
- ◆ *“I don’t have stress anymore...I don’t have anything. I get numb, I’m so tired. ...I’ve gone beyond stress...there’s no way to express it to you.”*
- ◆ *“I was just looking around there thinking, I honestly don’t know where to start, what am I doing today? I want to go to work at Qwik Trip...at Qwik Trip something good can happen.”*

The following provides a common scenario and the resulting fatigue and frustration:



- ◆ *“Yeah, I care for my wife [about 6 years]. She’s only 64 years old. Her mind doesn’t correspond with her hands or her feet...any moving whatsoever. Because she, [you] have to spoon feed her, take her to the bathroom and then she doesn’t want to sit down when I get her to the bathroom. She doesn’t know when she has to go to the bathroom. She gets very ill, you could say it’s mean. She’s getting that way. She tells me she wants me to leave. I’m there seven days a week, 24 hours a day. I can’t leave her....She does not want to get a bath whatsoever. Never wants to get a bath and get her hair washed...I’m afraid I’m starting to come apart inside..I do...Okay, sometimes I may look at her and she’ll just be sitting there on the couch leaning over like this...sideways...and I walk in there and I look at her and I just stand and cry.”*

The contextual issues that compounded the compassion fatigue in the previous groups were beliefs about who “should” be assuming responsibility for caregiving and the frustration of not having specific resources available or accessible to assist in the caregiving process. These factors indeed continued to hold true. Additional contextual factors that were more evident in the five new groups included a) mode of entry into caregiving, b) the number and ages of the persons they were caring for, c) the level of intensity of caregiving, and d) their own health issues.

Mode of Entry

The participants in these groups stated they were caring for their loved ones for varying amounts of time....from 3 months to over 20 years. The following serve as examples as to the mode of entry into caregiving or how they came to be caregivers, which often seemed to be precipitated by a crisis event:

◆ “...my mother’s 94 and she lived by herself...she lived 7 miles from me. And I would check on her every day there about nine years. So, one afternoon late she decided to go to the peanut field to get her some peanuts. So, she fell and she couldn’t get back up. And, so it got closer to night so we went down there and couldn’t find her anywhere. She wasn’t in the house....We found her up the little dirt road where she had tried to slide from the peanut field to the house. Well the fire ants had eaten her up. So the EMTs came and got her and carried her to the hospital and since then we brought her to the house.”

◆ “She’s [my mother] be 84 in April. She almost got burnt up in a house fire. I had just come home from work. I was going to take her medicines and she came out of the house and all her clothes were burnt off of her. Her hair had burnt off of her and I called 911 and got them out there. ...she was swollen and looked like a monster...didn’t know she was in the world.”



◆ “We live in a motor home and have ever since we have been married. I thought I could care for him better in a smaller space....We were going to Florida and we stopped at a rest area. We came back to the motor home and he said, ‘How do I make it go?’ This is a 38-foot piece of motor home and I thought [raised her eyebrows] ...but he still wasn’t willing to let me drive. And, then when we got parked and he said, ‘How do I make it backup?’ This was the last time he drove. And...then he tried to jump out of the car going 75 miles per hour on the expressway because he thought I was his mother and his mother couldn’t drive and was going to wreck us. ”



From these and many other examples shared by participants, it seems that one of the main precursors to participants’ perceiving themselves as caregivers was indeed a crisis and the resulting physical care or increased assistance with activities of

daily living. However, similar to the way that persons have symptoms of Alzheimer’s [and experience the consequences of them] before they are officially diagnosed, it appears that caregivers were often providing various levels of care [ie. cooking, cleaning, daily checks] for extended periods of time before they were actually providing “physical” care and considered themselves as caregivers.

Double and Triple Duty Care

As was true in the previous groups, these individuals were often caring for more than one person at a time; providing double and triple duty care.

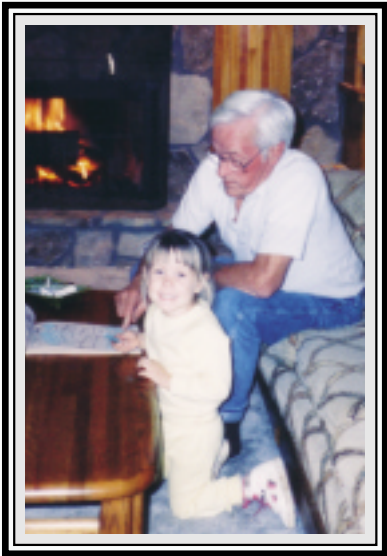
◆ “I care for my mother, she’s one hundred last month.....Now I just found out last week my husband’s got dementia real bad and he’s had open heart surgery. And I’m raising a special needs grandson that’s ADD and all. I had to take him - my daughter’s got cancer.”

◆ “I have been taking care of my mother since ‘85. She’s, she’ll be 84 in April.....I am her caregiver plus [I have] custody of a four year old.”

◆ “My husband and I have his mother with Alzheimer’s who is 92 and my father who will be 95 and my mother just passed away week before last...and my husband is a heart patient.”

◆ “....three years ago I moved my Mom and Dad in a mobile home behind our brick home....and I have a husband who also had a brain tumor removed a couple of years ago.”

◆ “....I’m taking care of my 75-year-old husband who has had a series of illnesses for the past ten years. I also have a mentally retarded daughter who has been under my care.”



Of particular note in these groups was not just the numbers of persons they were caring for but the variance in age of the those persons. These were age groups with potentially different care demands and different resources needed to meet those demands. While caregiving is often viewed as the same for all groups, the challenges of someone who is middle aged and caring for a 100-year-old individual and a four-year-old warrants serious consideration and can have considerably different implications for support.

Level of Care Intensity

As much as the length of caregiving and the number of persons being cared for, it is important to note the level of intensity of physical care provided. The stories shared by these participants were those that might have been shared by skilled providers at long-term care facilities in the not so distant past. The following provides examples of the level of care:

- ◆ *“There’s been many challenges but there have been many rewards as well. My parents moved in with me five months ago after my mother had a stroke.*

My father had a stroke, his first stroke, two and a half years ago, and he became total care. They lived with me for awhile, but then they wanted to go back home. With a lot of support they moved back home. But, they lived very nearby. Mother was the primary care person. I was in the background, but I was really more than I let her realize, because she was losing her vision and her health was poor.”

“My father is blind, (he) has Alzheimer’s, he’s paralyzed... my mother had a massive GI bleed... and then she had a stroke in July... she can’t speak... She’s paralyzed, so she is total care as well as my father... I just honestly feel like if they weren’t with me I wouldn’t have them alive, because they are fragile.”



- ◆ *[husband has leukemia] “Because when I first brought him home they say, well, nothing else they could do for him and I had to flush the tube hanging out of his heart...I had to stay there until I learned how to do these things and they had everything set up when I got home...He developed two hip sores, we have to turn every 15 minutes now. And now one coming in his back...I’ve dressed his heels...and keep the heels dressed.”*

- ◆ *[Mother was in a fire and severely burned...in a burn unit for 3 months]. “I stayed up there... slept on the floor... chairs for three months. Had to put my job on hold. So, when I brought her home I had to take care of her because she had a trach, she has all kinds of machines and things I had to learn to operate and do...She still has the trach and I have to suction it out. And then I have to...she’s*

a bad diabetic...she has oxygen at night. She has the oxygen machine in her bedroom. Then I have a humidifier. Then she gets those Albuterol treatments I give her....there’s a lot of nights I don’t even put night clothes on...if I get to sleep I do it sitting on the couch or in a chair. It’s been that way since ‘85...”

- ◆ *“[My mother]. She has had encephalitis, which the doctors said when she had it, said her fever was so high that it messed up some of her membranes. She’s had a triple bypass...She has swelling of the legs. When they did the surgery, it messed up her throat...she cannot swallow or eat good. She chokes constantly. She falls a lot...This time she fell and spent three hours in the floor till she got to the phone and called me...She has problems with her bladder...every time she stands she just goes on herself... Her speech is slurred real bad...she’s just limited.”*



In addition to the physical care that is necessary, the psychological or emotional stress that comes from caring for loved ones is evident in the following statements:

- ◆ *“I take care of my mother...It’s been going on over twenty years. She can still talk to you but she’ll repeat things to you. She worries a lot. She has to have heart surgery. You know I take care of her... causes a lot of problems at home. My wife complains that I don’t spend much time with the kids. But I tell her, ‘Ain’t nobody else gonna help her’....I told my wife, even if it costs me my marriage I’m not going to put her in a nursing home. If I have to I’ll take care of her....I’m trying to get her some help so somebody can sit with her so I don’t have to worry about it....It’s stressful because I worry about her. I wonder if she’s fell or hurt or whatever.”*



- ◆ *“...a man’s point of view is going to be different just like there’s gonna be a lot fewer men caregivers. There’s a sense of frustration and this comes out of...it’s your own personal inadequacies because you think you’re supposed to be able to do something...but you can’t.”*
- ◆ *“And it scares me because she [mother] been my best friend for so long...So, it’s just really hard, the idea that I’ve been so close to her and she’s been my confidante for so long and my best friend and I feel like I am losing my best friend...it’s a real loss.”*



Caregiver Health Issues

Lastly, the health issues of the caregiver also provide context for the compassion fatigue and frustration experienced. The following examples demonstrate how, in some cases, the concern was how their own health problems interfered with their caregiving abilities and in others it shows how caregiving indeed exacerbates their health issues.

“They just found out that I have Hepatitis C and my doctor said because of my liver enzyme with my blood pressure...I mean the diabetes that’s what they kept looking at it for....they want to go in and do a biopsy of the liver....we had an MRI this morning.”

“Finally, they put her on hospice because of her age, not because she’s dying...in order for me to get some rest...because I have got medical problems. ..I’ve got diabetes and high blood pressure and heart failure and all this other stuff. The stress gets me down some-times. I’ve tried to get disability and because I’m not laying flat in the bed and because I’m saying I’m taking care of them...you’re not disabled. They don’t realize...I have no re-sources toward medicines and I’m on about 8 different kinds.Well you’re taking a shot [insulin] every morning you have no idea what your blood sugar is cause you can’t buy that strip. ...you’re playing Rus-sian roulette with your life.”



“...this past two years, I mean I was a pretty vigorous person. Unfortunately, this arthritis kicked in and now I have to wear a brace on my leg. The walking, I mean it’s an inconvenience, but it really gets to be an inconvenience when you start to take care of somebody and they getting up and down. You don’t realize how many times you’re up and down until it gets to be a problem. [His doctor told him] ‘You get help or you’re going to die.’”

“ But I got very sick this year and I was just not eating right and running....And I would just grab the cake and I came down with diabetes. When I went to my doctor my blood sugar was 348. I didn’t even know I had sugar. But it can come from stress. It came back the other day...about a month ago and it went up again to 300 and then it dropped to 41 and he told me I needed to go to the hospital.”



Six Major Experiential Themes

Six major experiential themes were revealed in the data:

- 1.) Lack of Information and Coordination of Resources;
- 2.) Needs Exceed Availability;
- 3.) Ageist Providers;
- 4.) The Lone Caregiver;
- 5.) Pushing Against the Tide; and
- 6.) Living a Dilemma.

The first three themes existed in the previous data and were noted in the original report. The last three themes are discussed here with supportive data from these five focus groups.

Lack of Information and Coordination of Resources

A sense of frustration was clearly evident as these participants described their inability to locate information on services, both specific and general caregiving services, despite their many efforts. They described how they attempted to locate this information on their own and then turned to those who they traditionally counted on for this information [ie. doctors, health department, aging agencies]...still to no avail.



“...we can’t get off the ground. I know there are resources available from a place...a program called Community Care. I know it’s there, but you can’t get off the ground, you can’t get any help. And that’s what aggravates me.....I’ve called everybody. I have spent days on the phone and I don’t know what else to do. I know the resources are there but it’s like you can’t get to them.”

“...and I started looking for a support group and didn’t know how to find it. I was not from this area...I didn’t know how to reach the resources. I went to the health department [in the area]. They didn’t know anything about any kind of help group. I went to the senior center. I thought surely they would know. They didn’t know anything about it. I don’t remember how...I think I saw a notice in a paper and finally got me to one and... then we

“A lot of times I get frustrated because I’m the only one making all the connections to the other agencies ... calling legal services ... calling here ... following up. I’m always the one making that call to check and see if the job is being done or if legal services did their part or whatever. So, yeah, what she’s saying is true, you feel very frustrated...”



were able to make connections...I was really shocked that the health department in a county did not know anything available for Alzheimer's in that county. There is just some breakdown in communication... that a place that should be providing health care for a county knows nothing about Alzheimer's."

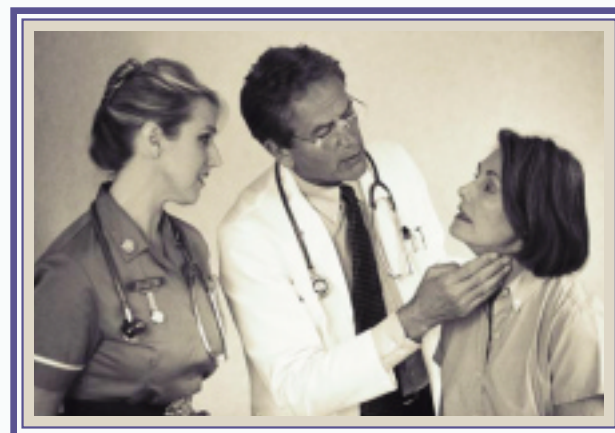
◆ *"Her doctor is no help... And I again I referred to this thing (CCSP)... the lady in my church she tried it for her mother on her own and didn't get*

anywhere. She got her mother's doctor to call them and it speeded up the proces. So I said 'All I am asking you to do is call and talk to them and tell them that we need some help.' The response I got was, 'We really don't know what's available and we can't really help you.' So he knew nothing ... his nurse knew nothing... it was a dead-end road."

◆ *"I had to have some tests done at the hospital last week. I'm supposed to get the results back today. If it happens the way I'm kind of expecting I'll have to go in the hospital. And at this point I have no idea what to do with my mother."*

◆ *"I think one of our biggest problems is information... where do we go for this... who knows what?"*

◆ *"I know it's out there it's just....you can't get to it. And that's what's aggravating. There's too much red tape."*



Each participant experienced his or her own degree of frustration related to this theme, but without a doubt the lack of information and coordination of resources can take it's toll on an already stressed system. The following is a statement from a caregiver helping to care for his mother:

◆ *..and here are people that need help...that have worked their whole life...paid their taxes their whole life and can't get it, and that is wrong. I can understand why somebody would go ballistic and go to a place and want to kill everybody in there. I can understand that. When you work your whole life trying to find...you know help that is out there and you can't get to it...what are you supposed to do?"*

Needs Exceed Availability



The needs of caregivers are varied, and the resources to meet those needs are perceived to be limited. What has been shared, again, by the caregiver groups is that, too often, the needs exceed what is available or accessible to them. In some cases, the need was financial in order to purchase the services needed. In other situations, the service was needed because they were unable to provide it themselves. A predominant pattern under this theme was the frustration of knowing there were services available that they qualified for but, because of the increased demand, they were placed on a waiting list of unknown length and duration.

◆ *...unfortunately, some of us aren't financially able to handle a lot of the expenses that go along with caregiving. I had to quit my job and retire for my social security in order to take care of my mother..."*

◆ *...we've signed up for the program [CCSP] but we haven't gotten on any of them. They keep saying we're on the next, when they pull up the next list....We'll be on the next list, but so far we haven't been called."*

◆ *"...I'm on the waiting list. Yeah, they don't have funds available every time."*

◆ *"[Takes care of his mother]. It would be nice [having respite with varying hours/days]. I haven't been outside the house after sun-down since my wife passed. She died March of last year...this March will be two years....I'm limited on being able to go to church. I can't go to evening services".*

◆ *"...she was saying that her husband draws \$65 too much...that's where a lot of this is falling into ...we make too much money. We don't have enough money, we can't hire private help, and we don't fall into the other category...what do we do?"*
"Because being on the waiting list we need help now, we don't need help six months down the road. We need help today."

HOSPITAL
EQUIPMENT
AND SUPPLIES

POSTURE

EYECARE

Dental Health

ARTHRITIS

- ◆ [referring to 64-year-old mother with Alzheimer's]. "We were trying to put her on disability...can't do that. She's not old enough for Medicare...you know Dad has the drug card that the drug company put out because he's over 65. But, see it doesn't apply to her because she is only 64. It's like you're fighting an uphill battle."

- ◆ "And I've got a letter back from [location] that says she qualifies...she's eligible for it but, they say there's a waiting list. I can't get to that."

- ◆ "She's liable to get up in the morning time and try to go to the bathroom and just fall...she hits her head...I may not find her for days.....I got her on a waiting list.....they said it could be a month, it could be a year....there's such a long list, they don't know when they can get to you."

"Like I had to tell my doctor that to you she is a patient, to me she's a person, it's my mother. I love her--that's the thing, and she's more important than things."

- ◆ "I called the community people before hospice came and they said they wouldn't have anymore resources until after January...they were frozen".

In some cases what is the most apparent missing resource is staff. The following exemplifies this phenomenon:

- ◆ "...the nurses complained about the fact that they were short staffed [in the nursing home]. On Sundays I have to get up and cut her meat because there's nobody there on Sundays of course."
- ◆ "You know the CNA has constraints of under staffing... and then corporate comes down... and they are not addressing crap!"

Ageist Providers

In much the same way as the previous group, ageism showed up in stories shared in these five groups. Ignorance, disrespect, apathy, and complacency were all threads of the ageism that they suggested of providers. For instance:

- ◆ "...the whole medical profession needs to listen to what the person or the resident is saying..part of it is just making them see that resident as a real person ...not a child."
- ◆ "I saw this first hand [demeaning, disrespectful care] not long ago when I attended a care plan session for one of our residents...I sat down, I looked, I said "Where's my resident?"



[They said] Oh, she's in her room. [when they finally brought her in, they did not place her at the table]...she was perfectly capable of hearing and understanding. It's as if the resident doesn't exist."

- ◆ "...we couldn't find the right kind of doctor to go to. They kept giving him medication for depression...well, he wasn't depressed, that wasn't the problem."

- ◆ "In our hospital...to me they don't have enough knowledge or training in Alzheimer's...any type of dementia..they just look at you."

- ◆ "I tried to find a doctor in Chattanooga and I was sure as large as Chattanooga is...that I could find a doctor who could specialize in working with older people. The only one I found was in a nursing home and she didn't want to take private patients... They treat them like... after the age of 90...'Oh, we can't do nothing, so just let it go.'"

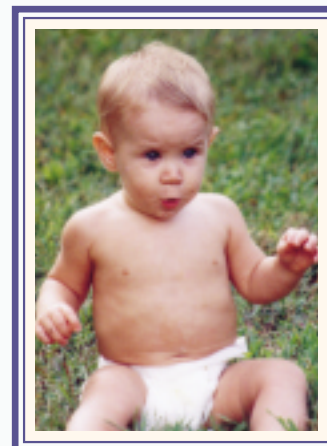
- ◆ "Her doctor is no help....he's got her on things [medicines] that is just costing Dad that she doesn't need."

- ◆ "Like doctors sometime when you have an older person...some of them feel like "well they've lived their life, you know, they're eighty something and they've lived the best of their life....and I don't like doctor like that because I think they are still living so there's hope and they should be treated like anybody else."

- ◆ "Respite care is fine...but are they [the staff] gonna take good care of her...and the issue I have is because they are not trained..they do not have a profession....They don't have the knowledge."

- ◆ "And then there's the basic issue of respect. I think CNAs and the residents both are treated with a tremendous lack of respect...CNAs are not going to treat residents with respect if they're not treated with respect. Especially with CNAs. They only in some cases have two weeks training, others six weeks training... There's no way anyone could understand this in six years, let alone six weeks."

"It's inhuman to me, I've had the physicians, the nurse, the doctors say 'Why don't you let him go? What are you trying to do? Sign this so if he stops breathing or whatever....I told one of the doctors I said, 'Listen, you're not God, you do not have the last word over him, you do whatever you can do for him and when you are through you discharge him to go home, I will take him home'...so it takes a lot out of you."



The Lone Caregiver

One of the primary new themes that came out of this data was related to the perspective that each participant saw himself as the sole caregiver; there was no one else to do it or to provide assistance. This belief seemed to hold true whether or not others were available, as the primary caregiver did not perceive them to be accessible or willing to participate.



- ◆ *"At times I have felt like no one cares. You just feel like you are all alone. It has been difficult...It seemed like the church neglected him for awhile. They help me if I ask for help with things but they don't come to me. Like we have a new preacher and he hasn't been to visit yet."*
- ◆ *"The only one that could help me is my brother. My other brothers and sisters wouldn't because they all say they've got a family. I've got a family too, don't stop me. Out of six children, my oldest brother and I are the only ones to help and I help more than any of them. I go over to the house and help her [mother] clean and check on her...cook her something to eat. None of the others will help her...because if she can't get me and she can't get my oldest brother, and they won't go over there and see her. I just ask God and I do most of it myself."*
- ◆ *"There is (sic) five of us, but she [mother] thinks that there is nobody but me. I am her caregiver plus [I have] the custody of a four year old.... So, it's just me. My sisters say 'I can't learn to do what you do'... because they can't suction her out, they can't do all this stuff they say."*



- ◆ *"I have nine brothers and sisters. My husband and I, before we moved back, we talked to everyone in the family. They assured us that we would have help. I had a brother living in the home with my mother and father... so we came home to help him. Two months after we arrived, he moved out.... so I had my Mom and Dad that I was caring for. So now that leaves me as the primary caregiver... It's difficult, because we had all these promises of help and they are not forth coming. The primary care responsibility falls to me."*



In some cases this belief was founded on the fact that there were no children or siblings to assist.

- ◆ *"I'm the sole caregiver of my 87 year old mother. My wife died March of last year and it's been just left with me since then. I have no siblings to help. I've got the whole ball of wax. So, it's kind of difficult. Especially being a man taking care of a woman."*
 - ◆ *"I'm an only child, so that tells you what I have to do."*
 - ◆ *"I think we all probably have a limit that we will individually go to... and every now and then I'll have a case like the lady who had no one to go to her house and get the dresser out of this awful house...But there was no one else to do it...so I did."*
 - ◆ *"The only thing I can say is that maybe I get up and I do it [caregiving] everyday because I'm fearful that nobody else will do it. Nobody will follow through when I know that needs to be done so I'd better do it because it needs to be done. I just know that if I don't do it then it won't get done...."*
- In other circumstances, children, siblings, or friends were available but it was not perceived as appropriate or acceptable by the care recipient.
- ◆ *"As the saying goes, I am the glue that holds the pot together. No brothers or sisters....nobody except my son - he's 35 - he's not married. ..Cause he can't get off of the job to do this."*
 - ◆ *"The care that my Mom needs we [me and my brother] can't do for her because we are boys...it needs to be a female to come in and do that and provide what she needs that we cannot do. So, I feel like our hands are tied."*

**You just
feel like
you are
all alone.**



◆ *"I have nobody else to sit... I'm either on the road [with her] or at her house. That's the biggest thing that I see...she don't want me out of her sight...that's stressful."*

◆ *"My wife is the proverbial clinging vine, she doesn't want me in another room let alone going out the door. She's alright as long as I'm doing housework... So, she wants you there... she won't let anybody else do anything."*



Pushing Against the Tide

Compounded by the perception of being the "Lone Caregiver" was the belief that, from the outside, they were being misunderstood or judged either for "doing too much," "not doing enough," or taking advantage of the care receiver. These caregivers were still attempting to do what they believed was right for the person receiving care and yet so many times standing in the face of criticism or lack of validation from others. Some described it as "pushing against the tide." The following excerpts serve as examples:

◆ *"The biggest surprise for me was the perception of other people towards my situation. It's overwhelming the number of people in my family that have said, 'You can't find someplace to put them?' And I always just stop and take a breath and say, 'I found a wonderful place for them right here in my house.' ...but it was shocking to me the people that would come in...even the physicians...they would come in and they'd shake their heads and walk out."*

◆ *"They don't understand....like you said physicians, they're like 'what are you doing? What's the point? Why don't you put them somewhere and forget about it? Anyway, that made me angry. And the other thing that used to make me angry is...they would be like 'Oh you take care of your mom? You're just sitting around*

the house all day; what's the big deal?' Yeah, you don't have a job. You don't go to work, that's no big deal."

◆ *"That opinion is really hard because I don't work either and people think you're just at home all the time...you're not doing anything and that you haven't used very good judgment."*

◆ *"But there was no one else to do it...so I did.....And I know I'm being shamed over there [referring to others within the group]."*

◆ *"It feels like they are stabbing you. It's like everything that I'm doing is...they're questioning... it's like they think we're stupid. 'Why would you do this to yourself? Just get it over with, just get rid of them. My brothers said to my husband and I, 'How could you quit your job? I could never quit my job.' They don't want to get too close because they feel like you're gonna ask them to help."*

◆ *"Last year, with my aunt who is 90 now, over 90 years old. She became critically ill in her home. She still lived alone with her dog and had to be put in a nursing home. Well, you know the nursing home kept her for a short time. And she had reached the point where she was able to ambulate by herself with a walker. But, she knew clearly what she wanted...Her whole community of friends and everybody was like 'you can't let her go home.. you have to stop her from going home.' But she went home, she had Meals on Wheels, she had homemaker aides from DFACS that come twice a week. She still has periods of confusion...she still has periods where she is incontinent..she still has times that she probably doesn't eat like she should. But this lady is so much happier. You know I had people calling me from up there, after I came back home. 'You've got to come up here and put her back in a nursing home' and I had to explain to them, I can't put her back in the nursing home...you can't force somebody in a nursing home if they don't agree to it..it's her choice."*

Living a Dilemma

This theme is reflective of yet another layer of complexity that exists in caregiving.... whereby caregivers are faced with situations and making choices between equally unsatisfactory actions. For instance, one may be very willing and desirous of caring for an aged parent but have to quit their job in order to do so. Quitting their job may not be an option because they would have no way to provide for themselves or their parents, but not taking care of the parent is not satisfactory either. This theme had the feel of being "between a rock and a hard place." Variations on this theme were revealed many times throughout these caregiver groups. One participant described a situation where a decision had to be made between perceived safety and individual choice:

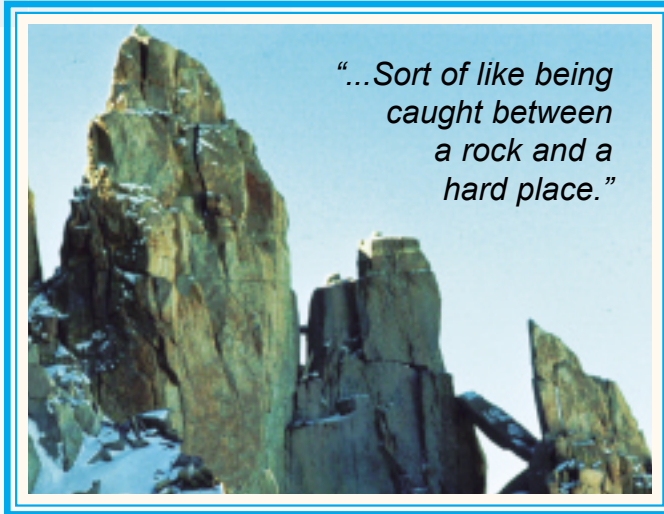


“Those are the hardest things when you have to advocate for something that’s happening that’s harmful to a resident or keep your mouth shut about something that’s happening that’s harmful to a resident.”

“It most certainly is [hard] because when you have to advocate for someone to go home that in your mind you know that individual doesn’t really need to go home. But what I think and what I feel doesn’t matter, I have to focus totally on what that resident wants and what that resident thinks and what he or she feels. I had to advocate for a blind resident to go home and live with a caretaker who was a drug addict or an alleged drug addict. Nothing would have it but she go home. She did and tried it. But it was her choice, broke my heart, but I advocated for what she wanted.”

Others spoke of the dilemma in making requests for an exhausted resident and an overloaded caregiver:

“It’s overwhelming. Cause I remember being in a facility just a few weeks ago from like 4:30 till about 6:00 at night and I’ve been doing this for sixteen years. But I stood there looking around going, ‘Where do I start?, What do I do? Why am I here?’ You know because there were so many issues they were just hitting me, every hall I went down there were more issues. And it was you know, a resident saying ‘I’m so tired, I’ve been sitting in this wheelchair all day long...all I want to do is go to bed’. And I know it’s going to be two hours before they [staff] have time because that’s what it is every night. And when I look around for the CNAs, there was one CNA on that hall and she was working her rear off trying to do the best she could and you know I could have gone to her and said ‘Excuse me, this resident wants to go to bed right now, could you take care of that?’ And she would have done it because I’m the ombudsman, but I didn’t feel like it was fair to her either or to the resident because she was trying to get into bed. You know the nurses were trying to pass medicine, some were feeding in the dining room and it was obvious residents’ needs were not being met and this is at one of the better facilities in [location] that had a great reputation and I was just looking around there thinking, ‘I honestly don’t know where to start.’ ”



“...Sort of like being caught between a rock and a hard place.”



“I’ve had several experiences with talking to the CNA and when a resident voices a complaint about ‘I have to wait so long for this or so long for that’. I’ll ask the CNA and I’ll say ‘How many residents do you have? ‘Oh 12 or 13’. ‘How many are total care?’ ‘Well more than half’ and then that CNA is in trouble for talking to me, you know. I’ll come again and he or she is doing that because they were called on the carpet...You know the CNA had constraints of the under staffing, overworked, underpaid, treated with disrespect... often times, the administrator’s hands are tied because of corporate, you know... and it’s very frustrating talking to residents and then you get into all these other things: ‘well, please don’t say anything I’m afraid of retaliation’... family members the same type of thing...well, what can you do? And I’m thinking, I can’t do jack!”



Many of the participants spoke of the dilemma of having nursing assistants coming into the home. All described the need for respite and at times they would use this service, however having outside assistance was often perceived as more work or doing more harm than it was worth. Here is one participant’s story:

“Well...they do sometimes send caregivers... send people as caregivers to take some hours off. But, it always seems to be my problem is that I have to sit in with her [nursing assistant] and another thing you gotta watch them all the time. One time they will come in and do a little something for you. But the last time all they wanted to do was sit. The last lady that came she was up in years...she was sort of like a boss with my husband and I would go in and talk to him and her together and I tried to suggest to her to let him do things..it was really a disaster...I left to go somewhere and I come back...my husband, she had him in the bathroom. She sent him back into the living room and the door was open and I warned her and warned her and warned her NEVER to leave that door unlocked. Now, the door was open, he was right out the door...he went down the steps, he got on the side of the street started running and the first thing you know he fell...bruised himself all up...he broke his arm. Caregivers, I could have sued them for everything they had. My granddaughter was downstairs and she heard that woman talk to my husband like he was a doghe was crying at the table...It was a disaster.”

For others the dilemma presents itself around the decision of where care is provided, at home or in an outside facility like a nursing home.

“...Because I never want him to go in a nursing home, that was just unthought of. With his condition, I need a lot of equipment at the house to take care of him properly... my responsibility is to take care of him, that’s what the Bible told me, that’s what the Bible teaches... I have to see because it’s my duty to be there..but it’s my duty to be there but I can’t go any further...I can’t do what a nurse can do..It’s nice to be at home with him but everyday you got to be there.”

And lastly, the diversity of opinions in regard to care serves as a dilemma in many cases. One participant described in this way:

“...you get a call from a family member who has complaints and you go see a resident...and I’ve had residents say to me ‘Oh my daughter she blows everything up...she gets upset over everything.’ You know, there are those times that residents do not want us to do anything or don’t want to tell about what the problem is because they’re fearful. There are also many people, particularly in our elderly population, who don’t want to cause waves, don’t want to get somebody in trouble, or ‘I’ll just do what the daughter wants and they will go along.’ And we are there to be the person who says ‘No, it’s what you want, we’re here to help you not have something forced on you, whatever that something may be,’ even if it’s something that we know would, healthwise, be best for the resident... And we’re there to speak for that choice even if it’s going to be detrimental to their health and goes against what everybody else thinks... ‘You’re being abused here and you don’t want to leave, ok. I’ll be back next month.’ ”



Focus Group Recommendations

From each of their stories about caregiving, the participants shared what they thought would be helpful for them to continue quality care for the individuals in their care. The majority of them concurred with the participants in the first report which included a) the need for more coordinated information on services and providers, b) the need for more services with a particular emphasis on respite care in the home, financial assistance, and emergency services for caregivers, c) more adequate training for providers at all levels, and d) more financial and backup support for families and nursing assistants.^{1,2}

Additional recommendations from these five groups included the following:

Education of the Faith Community
Several persons raised concerns that the church served as support as long as the loved one had an acute illness. However, when the nature of the disorder became more chronic, the support of the church seemed to diminish and was sorely missed. The recommendation was made that the church community be given reports like this one to

learn of the reality and the stresses of caregiving as a way to prepare themselves for outreach work.

Social Support of the Caregiver
The need for specific services has been evident in all groups. The need and request for more social support, such as “carrying on an adult conversation” with someone, came out in these five groups. It was recommended that even a “friendly visit” or “friendly telephone call” would be welcome in the midst of the caregiving chaos. This will become increasingly important as the number of caregivers decreases and the number of those they are caring for, along with the variance in age, increases.

Contingency Planning
While this recommendation is not entirely new to these groups, it seemed to carry a lot more weight particularly given the health status of many of the caregivers. Most responded that they did not have a plan in place, were not sure of how to put one in place, and that having no plan created a lot of background stress for them in the caregiving process.



Division of Aging Services

Strategic Plan for Caregiver Initiatives

In partnership with the state aging network, the Georgia Division of Aging Services (GA DOAS) provides leadership in establishing a comprehensive array of programs and services for Georgia's increasing number of older adults and their caregivers.

GA DOAS has established four initiatives to fully implement a continuum of care within Georgia for caregivers. A complete description of activities undertaken by the aging network related to these initiatives may be found on pages 5 through 7 in this report.

The GA DOAS continues to work collaboratively and support the Rosalynn Carter Institute, the Georgia Gerontology Society, the Georgia Alliance for Staffing Solutions, and AARP as they address issues such as long term care and caregiving.

The four initiatives of the GA DOAS are as follows:

Research and Strategic Planning

The Division has continued to conduct additional caregiver focus groups to add to the data provided in the original caregiver report, culminating with the publishing of this report, which details the findings from five groups with family caregivers and ombudsmen. As resources are available, the GA DOAS will conduct focus groups targeting the interfaith community statewide.

Education and Training

The findings and recommendations from the caregiver focus groups are utilized by the Division and the aging network in developing curriculum for caregiver

education and training. A variety of education/training formats have been used to reach both family and professional caregivers, including support groups, one day workshops/seminars, and multi-part caregiver education series that take place over the course of several weeks. Evaluations of education/training sessions are routinely completed by caregivers attending events, and indicate that caregivers continue to seek information about available services, how to access services, how to provide personal care without injury to the caregiver or care receiver, and dealing with behaviors of persons with dementia.

Program and Resource Development

Through the continuation of caregiver research, GA DOAS now has data which can be used by Area Agencies on Aging (AAAs) to identify issues and trends in caregiving within their regions and as a basis for planning needed programs and services. GA DOAS is working with Dr. Rhonda Montgomery, a prominent researcher on caregiver issues in the United States from the University of Wisconsin on field-testing a new caregiver burden scale. AAAs are helping to determine the instrument's uses for 1) prioritizing caregivers for receiving services; 2) targeting services more efficiently and effectively, and 3) identification of needed caregivers resources for long-range program planning and development.

Information Dissemination

The original *Caregiving in Georgia* report has been posted on the Division's website. Presentations on Georgia's

mobile day care, caregiver mediation project, and self-directed care programs have been made via tele-conference, and the United States Senate Special Committee on Aging.

With leadership from the Atlanta Regional Commission Area Agency on Aging, Georgia's AAAs have developed

and funded a caregiver magazine entitled *Georgia Generations*. Published quarterly by JAM Publications, the magazine has featured topics such as affordable prescription drugs, grand parenting, depression, and personal histories. Additionally, each feature includes an article written by each Area Agency on Aging regarding particular programs and services within its respective region.

Division of Aging Services of the Georgia Department of Human Resources

<http://www2.state.ga.us/departments/dhr/aging.html>

References

1. Scott, C. B. (2002) Caregiving in Georgia: A State Report from the Georgia Caregiver Resource Center
2. Department of Human Resources website:
<http://www2.state.ga.us/departments/dhr/aging.html>
Choose link to home page for the Division of Aging Services.

AREA AGENCIES ON AGING / LEAD AGENCIES

PLANNING AND SERVICE AREA	COUNTIES INCLUDED	AREA AGENCY ON AGING DIRECTOR	PHONE AND FAX NUMBERS
Atlanta Regional Commission	Cherokee Clayton Cobb DeKalb	Gwinnett Henry Rockdale Taliaferro Warren Washington Wilkes	Tel: 404 / 463-3100 FAX: 404 / 463-3264 Aging Connection: 404 / 463-3333 Toll Free: 800-676-2433
Central Savannah River Area	Burke Columbia Glascok Hancock Jefferson	Jenkins Lincoln McDuffie Richmond Screven	Tel: 706 / 210-2000 FAX: 706 / 210-2006 Toll Free: 1-888-922-4464
Coastal Georgia	Bryan Bulloch Camden	Liberty Long McIntosh	Tel: 912 / 264-7363 Information Link #: 1-800-580-6860 FAX: 912 / 262-2313
Coosa Valley / Northwest Georgia	Barrow Catoosa Chattooga Dade Fannin	Paulding Pickens Polk Walker Whitfield	Tel: 706 / 295-6485 FAX: 706 / 802-5508 Screening for Services: 1-800-759-2963
Georgia Mountains	Banks Dawson Forsyth Franklin Habersham	Stephens Town Union White	Tel: 770 / 538-2650 FAX: 770 / 538-2660 Toll Free: 800 / 845-5465
Heart of Georgia Altamaha	Appling Bleckley Candler Dodge Emmanuel Evans	Toombs Treutlen Wayne Wheeler Wilcox	Tel: 912 / 367-3648 FAX: 912 / 367-3640 Toll Free: 888 / 367-9913

AREA AGENCIES ON AGING / LEAD AGENCIES

PLANNING AND SERVICE AREA	COUNTIES INCLUDED			AREA AGENCY ON AGING DIRECTOR	PHONE AND FAX NUMBERS
	NAME OF AGENCY ADDRESS				
Middle Georgia	Baldwin Bibb Crawford Houston	Jones Monroe Peach	Pulaski Putnam Twiggs Wilkinson	Amy Tribble, AAA Director Middle Georgia RDC 175-C Emory Highway Macon, GA 31217	Tel: 478 / 751-6466 FAX: 478 / 752-3243 Toll Free: 888 / 548-1456
Northeast Georgia	Barrow Clarke Elbert Greene	Jackson Jasper Madison Morgan	Newton Oconee Oglethorpe Walton	Peggy Jenkins, AAA Director Northeast Georgia RDC 305 Research Drive Athens, GA 30610-2795	Tel: 706 / 369-5650 FAX: 706 / 369-5792 Toll Free: 800 / 474-7540
Southeast Georgia / South Georgia	Atkinson Bacon Ben Hill Berrien Brantley Brooks	Charlton Clinch Coffee Cook Echols Inwin	Lanier Lowndes Pierce Tift Turner Ware	Wanda Taft, AAA Director Southeast Georgia RDC 1725 South Georgia Parkway West Waycross, GA 31503-8958	Tel: 912 / 285-6097 FAX: 912 / 285-6126 Toll Free: 1-888-732-4464
Southern Crescent (Formerly Chattahoochee- Flint/McIntosh Trail)	Bufts Carroll Coweta Heard	Lamar Meriwether Pike	Spalding Troup Upson	Bobby Buchanan, AAA Director Southern Crescent AAA P.O. Box 1600 Franklin, GA 30217-1600	Tel: 706 / 675-6721 [Alt: 770 / 854-6026] FAX: 706 / 675-0448 Toll Free: 1-866-854-5652
Southwest Georgia	Baker Calhoun Colquitt Decatur Dougherty	Early Grady Lee Miller Mitchell	Seminole Terrell Thomas Worth	Physical Address: 13273 GA Hwy. 34 East Kay Hind, AAA Director Southwest Georgia COA 1105 Palmyra Road Albany GA 31701-1933	Tel: 229 / 432-1124 FAX: 229 / 483-0995 Toll Free: 800 / 282-6612
Lower Chattahoochees	Chattahoo- chee Clay Crisp Doolley Harris	Macon Marion Muscogee Quitman Randolph Schley	Stewart Sumter Talbot Taylor Webster	Tiffany Ingram, AAA Director West Central Georgia AAA 1428 Second Avenue P.O. Box 1908 Columbus, GA 31902-1908	Tel: 706 / 256-2910 FAX: 706 / 256-2908 Toll Free: 1-800-249-7468